STATE OF TENNESSEE
DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF EMPLOYMENT SECURITY

APPEAL OF AGENCY DECISION

Please check the appropriate box: I am the ☐ Employer ☐ Claimant

Date Agency Decision was mailed: _____

Employer: _____

Employer Contact Name: _____

Employer Contact Phone Number: _____

EIN Number (if available): _____ - _____

Employee First Name: _____

Employee Last Name: _____

Employee Phone Number: _____

Employee Mailing Address: (Street, Apt No.) _____

(City, State, Zip Code) _____

Social Security Number: _____

Reason for Appeal (2,000 characters):

Date Completed and Submitted: _____

SUBMIT

LB-1069

RDA 1643